AFFORDABLE CARE ACT
MASSACHUSETTS IMPLEMENTATION UPDATE

May 6, 2011

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MA-ACA Website

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These Updates, published by the Executive Office of Health and Human Services (EOHHS) in consultation with the other state agencies involved in ACA implementation, will bring you news related to the implementation of provisions of the ACA here in Massachusetts.

Grants and Demonstrations

The ACA provides funding opportunities to transform how health care is delivered, expand access to care and support healthcare workforce training.

Grant Announcements

Screening, Brief Intervention, and Referral to Treatment with a Trauma Module. §4002. Announced 5/3/11. Funding will build on The Substance Abuse and Mental Health Services Administration's (SAMHSA) Screening Brief Intervention and Referral to Treatment (SBIRT) for alcohol and illicit drugs and test the value of adding a screening and brief intervention module for trauma. Eligible entities include nonprofits, state and local governments, tribal organizations, universities and colleges, community and faith-based organizations, research organizations, and health care organizations. 3-5 awards will be made from $5M in total funding. Up to $1M is available per year for 5 years. Applications are due 7/5/11.

The announcement can be viewed at: SAMHSA

Applications Pending

5/2/11 DPH submitted an application to the CDC for state supplemental funding under §4002 of the ACA, **Strengthening Public Health Infrastructure for Improved Health Outcomes, Supplemental Funds**. The supplemental funding will a) accelerate the Department of Public Health's preparation for accreditation, b) improve our web-based Massachusetts Virtual Epidemiologic Network (MAVEN) disease surveillance and case

management system and c) provide public health planning grants to 6 more public health districts, and d) provide implementation grants for up to 2 districts.
The grant narrative can be read on our website under the Grants and Demonstrations section at: MassGov

4/29/11 DPH submitted an application to the CDC for state supplemental funding under §4002 of the ACA, Healthy Communities, Tobacco Prevention and Control, Diabetes Prevention and Control, and Behavioral Risk Factor Surveillance System. The **Tobacco Cessation and Prevention Program, Supplemental Funds** will be used to expand and enhance tobacco quitline services. Funds will be used in partnership with the Massachusetts Department of Veterans Services to increase awareness and utilization of tobacco quitline services among Massachusetts veterans and their family members. This will enable the quitline to serve an additional 500 veterans or family members of veterans in FY2012. Approximately $6 million in funding, among 53 awards is available.

The grant narrative can be read on our website under the Grants and Demonstrations section at: MassGov

4/29/11 EOHHS submitted an application to CMS for funds under §4108 of the ACA, **Medicaid Incentives for Prevention of Chronic Disease Demonstration Project.** The MassHealth WIN (Wellness Incentive Network) initiative will promote participation in the following programs: Chronic Disease Self Management Program; Tobacco Cessation; Diabetes Self Management Education and Medical Nutrition Therapy for Diabetes Care. Incentives are tiered to support engagement, continued participation and follow-up in these programs. Indirect incentive payments will be made to providers of programs not otherwise covered by the Medicaid plan to support the member towards wellness. MassHealth will conduct a State evaluation of the program and participate in a national evaluation of all programs being funded by CMS. The proposal was developed in collaboration with the Executive Office of Elder Affairs (EOEA), DPH and the Department of Mental Health (DMH), with the Office of Medicaid serving as the lead agency per CMS requirements. The proposal leverages existing EOEA and DPH program networks to offer the incentive benefit statewide. CMS anticipates the funding level to support 10 States with between $5 million and $10 million during the life of the program.
Status Update: 9/27/11 Massachusetts did not receive a grant.

Guidance

5/6/11 CMS issued a final rule, as authorized by §3001(a)(1) of the ACA, to implement a **Hospital Value-Based Purchasing (VBP) program** that rewards hospitals for the quality of care they provide. Under the Hospital VBP program, CMS will evaluate hospitals' performance during a performance period based on both achievement and improvement on selected measures. Hospitals will receive points on each measure based on the higher of their level of achievement relative to an established standard or their improvement in performance from their performance during a prior baseline period. Their combined scores on all the measures will be translated into value-based incentive payments for discharges occurring on or after 10/1/12. For the first time, 3,500 hospitals across the country will be paid for inpatient acute care services based on care quality, not just the quantity of the services they provide.
Read final rule here: http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf
Read the CMS press release at: http://www.hhs.gov/news/press/2011pres/04/20110429a.html
Read the CMS Fact Sheet at: CMS

5/6/11 CMS issued a proposed rule that would **provide guidance to States on ways to ensure that people with Medicaid have access to health care services**. The rule creates a "standardized, transparent process" for states as they set their Medicaid payment rates and proposes a strategy of consistent and ongoing state-level review of rates to

demonstrate sufficient beneficiary access that does not only focus on provider payment rate changes but also looks at ongoing performance. For the first time, the rule would require states to "periodically monitor" enrollee needs, the availability of care and providers, and the utilization of services in their Medicaid programs to determine if it provides sufficient access to care. The proposed rule would allow states to resolve any provider access problems discovered through various steps, including "redesigning service delivery strategies, improving provider enrollment and retention efforts." The rule incorporates research recommendations made by the Medicaid and CHIP Payment and Access Commission (MACPAC). States will likely be collecting related information by 2014 as part of other performance standards and measures required under the ACA. Comments are due 7/5/11.
Read the rule at: http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10681.pdf
Read the CMS press release at: CMS

5/6/11 CMS issued a proposed rule that considers two possible options to set the **2012 Medicare payment rates for skilled nursing facilities** (SNFs). One option follows the approach laid out by the ACA and would increase SNF reimbursement by $530 million, which is a 1.5 percent point increase. The other option CMS is considering adjusts for an unexpected increase in nursing home payments during FY 2011. Under this option, CMS would restore overall payments to their intended levels on a prospective basis which would require reducing FY 2012 payments to Medicare skilled nursing facilities by $3.94 billion, or 11.3 percent lower than payments for FY 2011. In addition to discussing the SNF Prospective Payment System (PPS) payment rate update for FY 2012, the rule would implement §6101 of the ACA, which requires Medicare SNFs and Medicaid nursing facilities to disclose certain information in a standardized format to HHS and other entities regarding the ownership and organizational structure of their facilities. Comments are due 6/27/11.
Read the rule at: http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10555.pdf
Read the press release at: CMS

5/6/11 CMS issued a final prospective payment system rule regarding **Medicare payments for inpatient psychiatric facilities** (IPFs) which will increase an estimated 2.74%in 2012, slightly higher than earlier expected. Medicare payments for inpatient psychiatric facilities will increase an estimated 2.74 %in 2012, slightly higher than earlier expected. Rural IPFs are estimated to receive an increase in payments greater than 3% (an aggregate 3.8%). This rule implements portions of §3401(f) and §10322 of the ACA.
Read the rule at: http://www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10562.pdf
Read the press release at: CMS

5/3/11 IRS/Treasury issued Notice 2011-36, a request for comments on issues relating to the **shared responsibility for employers** provisions in the ACA, including §1513, as part of the federal process of planning for implementation of these provisions. Beginning in 2014, employers with 50 or more full-time employees that do not offer affordable health coverage to their full-time employees may be required to make a shared responsibility payment. In particular, the notice requests comment on possible approaches employers could use to determine who is a full-time employee. The notice also solicits input on how the Department of Labor (DOL), Treasury and HHS should interpret and apply the ACA's provisions limiting the ability of plans and issuers to impose a waiting period for health coverage of longer than 90 days starting in 2014. The notice seeks comment on how guidance under the 90-day provisions should be coordinated with the rules Treasury and IRS will propose regarding the shared responsibility provisions. Comments are due 6/17/11.
Read the notice at: http://www.irs.gov/pub/irs-drop/n-11-36.pdf
Please note that the notice does not constitute guidance.

Prior guidance can be viewed at www.healthcare.gov

News

5/4/11 CMS named Patrick Conway, the director of hospital medicine at Cincinnati Children's Hospital, as its **new chief medical officer and director of the Office of Clinical Standards and Quality**. He starts on May 9. Conway previously served as Chief Medical Officer for planning and evaluation at HHS and was a White House Fellow assigned to HHS' Agency for Healthcare Research and Quality in 2007 and 2008. Read more about the Office of Clinical Standards and Quality at CMS:
http://www.cms.gov/CMSLeadership/11_Office_OCSQ.asp

4/29/11 Kansas became the 10th state to apply for a state adjustment of the medical loss ratio (MLR) rules, asking for a gradual implementation of the 80% requirement over a 3-year period, beginning with 70% this year. The MLR rules require insurance companies to spend at least 80% or 85% of premium dollars on medical care. The ACA allows the Secretary to adjust the MLR standard for a state if the state can prove that meeting the 80% MLR standard may destabilize the individual insurance market and result in fewer choices for consumers.

Kansas joins 9 other states, including Louisiana, North Dakota, Georgia, Nevada, Kentucky, New Hampshire, Florida, Iowa and Maine, and the territory of Guam. On 3/8/11 the state of Maine was granted the first state-specific adjustment to the MLR rules that will allow its insurers to spend 65% on medical care.
Read the Kansas application: CCIIO
For more information on states and the MLR requirements visit the Center for Consumer Information and Insurance Oversight (CCIIO) website at:
http://cciio.cms.gov/programs/marketreforms/mlr/index.html

3/9/11 The Institute of Medicine (IOM), which has been tasked by HHS to make recommendations on the criteria and methods for determining and updating the "essential health benefits" requirement in the ACA, is also reviewing **women's preventive health**. The Committee, which is sorting out the issue of whether health reform will count birth control as preventive care, met for a 3rd time on 3/9/11. Presentations from Meeting 3 held on 3/9/11 can be found at:
http://www.iom.edu/Activities/Women/PreventiveServicesWomen/2011-MAR-09.aspx

Upcoming Events

Next Quarterly Stakeholder Meeting
Patient Protection and Affordable Care Act Implementation meeting
Tuesday June 21, 2011 from 3:00-4:00 P.M.
1 Ashburton Place, 21st floor, Boston

Don't forget to add our website to your favorites: www.mass.gov/nationalhealthreform